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Race and Mental Health: Past Debates, New Opportunities

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Given its pervasiveness in American social life, race as a construct and topic has a long history of scholarship and debate in sociology and a corresponding research literature, albeit not as extensive, in the Sociology of Mental Health. We argue that inquiries about race and its consequences tend to reflect existing attitudes during different time points. In this chapter, we examine some of the key frameworks used in sociology to study race and mental health. Rather than focusing on specific research contributions, we discuss the general themes that highlight how sociology contributes to the study of race and mental health and vice versa. A second purpose of this chapter is to focus on some directions that may help to advance the Sociology of Mental Health.

SOCIOLOGY AND THE STUDY OF RACE AND MENTAL HEALTH

Sociology provides some of the theoretical underpinnings on which race and mental health research are constructed. In turn, the Sociology of Mental Health contributes to the discipline by providing theoretical refinements and empirical evidence about how race is linked to psychological and emotional states such as through traumatic events, discrimination, and treatment biases. This reciprocity between the Sociology of Mental Health and the larger body of sociological work is evidenced in some of the common frameworks we outline below that have been used, over time, to study race and mental health. Our review also serves as a reminder that current studies on mental health are influenced by the social and political realities that frame discussions and conversations about race. Past debates have usually reinforced, often unintentionally, the social positions of racial groups rather than contesting the inequities found among racial groups. Support for one theoretical frame over another become solidified into ideological

positions about the nature of race, inequality and policy solutions. (Takeuchi & Gage, 2002).

The Early Biological View

Biological determinism or essentialism categorizes people into unequivocal groups based on certain traits such as skin color and phenotypes. These racial characteristics are assumed to be fixed and constant over time. Essentialism, which dominated scientific thinking in the 19th and early 20th century, promotes the notion that race is interwoven with physical, moral, and mental traits (Harris & Sim, 2001). Racial groups, accordingly, can be systematically arranged by prized traits (e.g., intelligence, personality) with whites at the top of the hierarchy. Scientific studies during that time, including those in the social sciences, did not contest the existing racial stratification system but tended to explicitly or implicitly maintain it (McKee, 1993).

Of course, essentialism was not uniformly accepted in the social sciences. DuBois (1903) and Boas (1927), among a few, argued that the status of racial groups was not due the lack of intelligence or motivation, but rather the consequence of inadequate opportunities. Despite these and related arguments, race as an important determinant of intelligence and other valued traits was popular in the general public and scientific papers, principally because it helped justify the treatment of racial groups during this period.

Enter Cultural Theories

In the early 1920s, culture began to replace biological theories of race. The University of Chicago's Sociology of Race Relations program formulated a new theory of race relations that emphasized how people of diverse races assimilated into the established culture. In their theories of assimilation, racial conflict and its resolution

involved a linear process of competition, conflict, accommodation, and assimilation. Further, assimilation of racial minority groups would improve race relations among groups (Yu, 2001). Much of this interest was spurred by the immigration of people from Europe, Asia, and Canada. The incorporation of white ethnic groups into the American mainstream, although not without protest, provided positive evidence of the assimilation hypothesis. African Americans and Asian immigrants, however, posed unique challenges for the Chicago School theorists which remain to this day (Alba & Nee, 2003; Tuan, 1998). Would American society overlook physical differences to allow non-whites to assimilate? Could Asian immigrants assimilate and break their ties with their home countries (Yu, 2001)? African American and Asian immigrants shared one major difference with white immigrants – they could not easily enter social settings without being identified as phenotypically different from white residents.

Theories of Racism

During the 1950s and leading into the 1960s, the civil rights movement marshaled in fundamental changes in approaching policies and programs to resolve racial inequalities in American society. Racist ideologies were seen as only part of the problem in eliminating racism; the focus was on the larger context of racialized social structure (Bonilla-Silva, 1997). Scholars and activists argued that without attending to racism as a fundamental component of the American social structure, it would not be possible to eliminate the root causes of discriminatory behavior against minority groups.

Accordingly, the social and public policies of the 1960s and early 1970s advanced issues of racial and economic justice in education, employment, and social services. The mental health field, which tends to move at a more conservative pace, also included studies and reforms intended to address institutional forms of racial bias. Some of the

first studies of the use of mental health services among racial groups begin in the 1970s and investigated institutional biases and its effects on the mental health status and mental health care of racial and ethnic groups. For example, in their classic study, Sue and colleagues (1974) showed that the existing mental health system was incompatible with the mental health needs of racial and ethnic minorities. This study led to a number of recommendations to reduce the biases against racial groups inherent within the mental health system. Despite the thrust of this early work, the political landscape began to change in the middle 1970s and refocused the discourse and scholarship on race from institutional analyses to one centered more on other social and individual factors.

Theories of Socio-Economic Status

In the 1980s and extending through the 1990s, racial bias, institutional racism, prejudice, and discrimination lost momentum as an explanation for inequities between racial groups in social, economic, and health indicators. Instead, socioeconomic status, or SES (also social class), grew in popularity as an explanation for racial differences. Since socioeconomic status is one of the strongest determinants of variations in health status (Krieger, 2001), much of the research over the past two decades argued that race effects will be reduced or disappear once SES is considered. SES refers to people's structural location within society based on representations of income, wealth, education, and occupational status (Krieger, Williams, & Moss, 1997). While researchers argue that race and socioeconomic position intersect to explain mental health problems (Neighbors, 1990), still others argue that SES may be part of the causal path that links race and health through economic discrimination (Cooper & David, 1986; Krieger et al., 1997). Some researchers focus less on race and more on the "fundamental causes of health disparities"

that are rooted in SES-related resources like money, power and access to knowledge (Link & Phelan, 1995).

SES became a common explanation for race differences for several reasons. First, if race differences are found, social phenomena such as SES, and not biology, explain these differences. Second, social scientists became sensitive about making inferences concerning race that can be construed as "blaming the victim" after Daniel Moynihan was criticized for making inferences about African American families (Wilson, 1987). Third, researchers had difficulty in fitting racial paradigms into the social, political, and health circumstances of Asian and Latino immigrants whose history in the U.S. varied substantially from that of African-Americans. Race was seen as a "black and white" issue. Fourth, some social scientists and policy makers saw programs and policies to benefit poor people as having a wider appeal than those that promote racial justice. Fifth, and perhaps most importantly, the social and political climate had changed dramatically from the 1960s to the 1980s. Enthusiasm for the role of the federal government to promote large-scale social change was tempered and issues of race and racial justice were no longer prominent on the national agenda.

Beyond SES

Over the past decade, there has been a renewed interest in studying race as more than a proxy for socioeconomic status. This revitalization was triggered by developments on at least two fronts. On one front, geneticists and social scientists agree that race as a biological measure lacks empirical support. For example, a recent study demonstrates that within a population, differences account for up to 95% of the genetic variation among individuals (Rosenberg et al., 2002). Contemporary social scientists also challenge essentialist notions of race by arguing that people make attributions about

groups based on stereotypes and prejudices that are tied to some physical traits (Omi & Winant, 1994). That is, race is socially constructed and conceptions of race change over time and place and are shaped by political and social needs. Racial categories carry with them implicit and explicit images and beliefs about racial groups that form the basis and rationale for treatment of group members. Race is particularly meaningful when members of a group are given limited power and denied access to desired goods and resources based on their social membership within that group (Winant, 2000).

While this review is not exhaustive, it does provide a glimpse of the major frames about race that have been influential in the Sociology of Mental Health. While all conceptions of race, even essentialist notions, are still operative at some level debates are often driven by a prevailing paradigm and an alternative framework that contests it. As indicated earlier, race versus SES discussion consumed much of the research on race and mental health in the 1980s and 1990s. While these inquiries have been healthy for the discipline, they can also become ideological when taken to the extreme and actually constrain research (Massey, 1995). For example, much of policy research on race puts race in the background rather than the foreground of empirical studies because they focus on SES (Myers, 2002). Conversely, race scholars seldom incorporate policy issues into their analyses. The result is a parallel set of empirical and theoretical literatures that seldom merge. Further, scholarship is not external to the everyday realities on race in society. Different theories and research on race can serve to, directly or indirectly, reinforce existing stereotypes, provide justifications for treatment of racial categories, or reinforce the positions of racial groups. Finally, our review suggests that the study of race is often limited to African Americans and whites; few studies address how race

impacts the lives of Latinos, American Indians and Alaska Natives, and Asian Americans.

NEW OPPORTUNITIES, NEW CHALLENGES

In this section, we address directions that may help explain the association between race and mental health. Since a number of excellent reviews of race and health have been written (see for example, Brown, Sellers, Brown, & Jackson, 1999, Ihara & Takeuchi, 2004; U.S. Department of Health and Human Services, 2001), we focus on some different challenges and opportunities that may prove helpful in the near future. We identify three critical gaps or issues in the literature in the study of race and mental health: (1) the omission of analyses of historical events that shape race relations, and specifically the intergenerational transmission of past traumas; (2) the assumption that social psychological processes are similar across racial groups; and (3) the inclusion of geographic contexts in understanding race and mental health.

Historical Trauma

An emerging area in race and mental health is a focus on inter-generational, community-specific trauma such as genocide, slavery, forced relocation, internments, segregation, and political oppression. Clinicians and some researchers have explored the effects of these traumatic assaults through diagnostic categories such as posttraumatic stress disorder (PTSD), anxiety disorders, and adjustment disorders (Evans-Campbell & Walters, 2006). Although these categories may encompass some of the symptoms related to such traumatic events, they fall short of capturing the extreme nature of the resulting distress or its collective and intergenerational impact. Moreover, these diagnostic categories offer little insight into the interplay between historical and current trauma responses.

One attempt to understand these assaults and their impacts is the scholarship on *historical trauma*, defined as the trauma that arises in response to numerous traumatic events experienced by a community over several generations (Brave Heart, 1999b). The trauma is based on events that are profoundly destructive and experienced by many members of a community (Brave Heart, 1999b). Historical trauma is conceptualized as collective in that it impacts a significant portion of the community and as compounding in so much as multiple events occurring over many years come to be seen as parts of a single, overarching traumatic legacy. A key facet of historical trauma is that it is passed on from one generation to the next, as descendents continue to emotionally identify with their ancestral suffering and pain (Brave Heart, 1999a). Indeed, research among diverse populations shows that children and grandchildren of survivors of historically traumatic events have high levels of current interest in ancestral trauma (Danieli, 1998; Nagata, 1991; Whitbeck et al., 2004). The psychological responses to such historical trauma may include guilt, anxiety, unresolved grief and mourning, and suicidality (Brave Heart, 2000).

According to Simon and Eppert (in press), traumatic historical events share two important characteristics: they are human-initiated and they evoke particular behavioral dynamics. Most notably, they elicit a need to simultaneously remember and forget. That is, while the public is drawn to recount and belatedly "witness" these events, the feelings evoked are so overwhelming that people are prone to shut them out of their psyches. These events may target communities or families directly, as in the case of internment or slavery, or indirectly when aimed at the environment in which people live. Environmental historical traumas include radioactive dumping on tribal lands, flooding of homelands, and the introduction of diseases into communities. Historical trauma can also result from

the inability to complete cultural and spiritual ceremonies (Evans-Campbell & Walters, 2006).

The intergenerational impact of historical trauma can be seen on at least two levels, the communal and the interpersonal. On a communal level, the response to an event may include immense and multifaceted losses such as the elimination of a "way of life" after slavery, internment, or relocation. The literature on historical trauma points to a number of similar losses including the loss of traditional spiritual practices or the loss of traditional role models for youth (Evans-Campbell & Walters, 2006). Emerging research illustrates the intergenerational response to such losses. For example, Whitbeck and colleagues (2004) interviewed Native elders in two reservation communities and found that although these individuals were generations removed from many historically traumatic events, ancestral losses were still part of their emotional lives.

Communal level impacts may also include second-order effects related to traumatic events. In a community that has suffered multiple losses, for example, a significant portion of the population might be more susceptible to substance abuse problems or family violence. In this way, the trauma continues to impact subsequent generations, leaving an increasing array of effects. Although the initial perpetrating event may fade into the distance of history, left unchecked by healing processes, the secondary effects of that event can actually amplify with each generation making historical trauma, as a type of trauma, particularly devastating and critical to understand.

At an individual level, the complexities of historical trauma make it difficult to distinguish the exact mechanisms of transmission, but traumatologists speculate that intergenerational transmission can occur through direct and indirect means. In the case of direct transmission, children may hear stories about events experienced by their parents

or grandparents and, consequently, experience vicarious trauma (Auerhahn & Laub, 1998). In the case of indirect transmission, traumatic events may lead to poor parenting styles which, in turn, may increase stress in children (Auerhahn & Laub, 1998). Family dynamics may also unconsciously foster indirect transmission. For example, Felsen (1998) found that some children of Holocaust survivors felt they were expected to fulfill "missions" for their parents such as the need to comfort parents, restore lost love objects, act out parental anger, and demonstrate the continued vitality of their community. Notably, these family dynamics are both a result of historical trauma and a mechanism of transmission.

Experiences of traumatic events among historically oppressed people are often varied and heterogeneous. However, some symptoms appear common among those affected by historical trauma are evident. Much of what we know is based on research with survivors of the Jewish Holocaust and their descendents. Early work in this area documented and explored a constellation of psychological symptoms sometimes collectively dubbed the "survivor syndrome" among survivors of the Jewish Holocaust. These symptoms include denial, agitation, anxiety, guilt, depression, intrusive thoughts, nightmares, psychic numbing, and survivor guilt (Barocas & Barocas, 1980; Eitinger & Strom, 1973; Neiderland, 1968, 1981). Among descendants of these survivors, however, symptoms often take a somewhat different form. The research here suggests that while higher rates of pathology in descendents are not common – rates of mental disorders among children of survivors generally fall within the normal range (Felsen & Ehrlich, 1990; Sigal & Weinfeld, 1989) – patterns of stress-vulnerability are. That is, when survivor children experience contemporary traumatic events, they are significantly more likely than controls to develop PTSD or sub-threshold PTSD (Yehuda, 1999). Moreover,

although their symptoms do not meet the criteria for mental disorder, descendents are more likely to experience symptoms of depression, higher levels of anxiety, mistrust, guilt, difficulty handling anger, and somatization over their lifetime compared to others (Bar-On et al., 1998; Barocas & Barocas, 1980). Notably, while an emerging literature on descendents shows areas of resilience and good adjustment among descendent populations (e.g., Kahana, Harel, & Kahana, 1988; Solomon, Kotler, & Milkulincer, 1988), research continues to demonstrate their vulnerability to traumatic stress (Danieli, 1998).

Similar transgenerational effects have been documented in other populations including among Japanese-Americans after internment (Nagata, 1991), American Indians in response to relocation and cultural genocide (Robin, Chester, & Goldman, 1996) and victims of the Pol Pot regime in Cambodia (Kinzie, Boehnlein, & Sack, 1998). In their research with the Lakota people, Maria Yellow Horse Brave Heart and her collaborators explored mental health and wellness after numerous collective, compounding historically traumatic events. They identified a collection of outcomes among the Lakota which they term "historical trauma response." This response is likened to the *survivor syndrome* and other symptoms common to Holocaust survivors and their descendents and includes: obsessive rumination about dead ancestors; continually reliving the past with a primary life focus on ancestor suffering; survivor guilt; unresolved mourning; depression; intrusive dreams and thoughts; use of coping fantasies that project oneself into the past (Brave Heart, 1999a, 1999b, 2000).

A host of factors can influence the level of distress among descendents in diverse communities. Arguably, the most critical factor affecting intergenerational transmission of massive trauma is communication around the events, particularly silence around the

events or guilt-inducing communication (Bar-On et al., 1998; Felsen, 1998; Nagata, Trierweiler, & Talbot, 1999). Not surprisingly, many survivors of traumatic events avoid talking about their experiences and related feelings (Nagata et al., 1999), particularly to their children. For parents, keeping silent about past atrocities may seem protective, but among children, silence can serve to shroud the past in mystery and misunderstanding. Children may feel anger and resentment over their parents' unwillingness to share information, feeling it signals a lack of empathy with their own psychological need for information (Bar-On et al., 1998; Nagata et al., 1999). Indeed, avoidance of and indirect communication around massive trauma are significantly related to poor mental health outcomes in descendants of survivors including paranoia, hypochondria, anxiety, and low self-esteem (Lichtman, 1984). That said, the impact of communication on transmission may be unique to different racial and ethnic groups. In communities where indirect communication is a cultural norm, for example, these mechanisms may work differently, making them particularly challenging to identify.

In addition, societal reactions have an important effect on individual and communal post-trauma adaptation and healing. Danieli (1998) has looked extensively at this phenomenon in relation to Holocaust survivors. In what he terms the "conspiracy of silence," Danieli describes a social context in which those who were not survivors were unable to contemplate the horrific nature of survivor experiences and, moreover, did not want to listen. As a result, survivors remained silent about their experiences leading, in turn, to an increased sense of isolation, loneliness, and high levels of mistrust (Danieli, 1998). In the U.S., acknowledgements of traumatic assaults perpetrated on cultural and ethnic groups are limited and, not surprisingly, people from historically oppressed communities routinely encounter societal reactions such as indifference, disbelief, and

avoidance. While there is little discussion in the literature regarding societal reactions to historically traumatic assaults in the U.S., it seems likely that many people are impacted by the tendency to ignore their painful histories.

RESEARCH IMPLICATIONS

Critical assessments are needed about the concept of historical trauma, the factors that influence it, and its impact on contemporary mental health in diverse communities. Preliminary scholarship in this area provides a base for rethinking the way trauma impacts historically oppressed communities over time. Yet as scholars begin to grapple with the challenges inherent in conceptualizing historical trauma, it is important to note that the concepts involved are complex, multifaceted, and often interrelated; as such, they do not easily lend themselves to clear answers. Indeed, only limited attempts have been made to operationalize and measure historical trauma. We need to understand the characteristics of historical trauma, how it is transmitted, and how it may manifest in different cultural settings. And perhaps most importantly, given that people from historically oppressed groups continue to experience high levels of trauma, we must begin to explore the cumulative and interwoven nature of historical and contemporary traumas.

One of the most promising areas of future research in this area focuses on the strengths borne out of enduring traumas. Although historical trauma has had negative impacts, affected communities have been quite resilient. For example, Cross (1998) notes that ex-slaves and their descendents emerged from the trauma of slavery with strong family bonds and a communal commitment to education. Evans-Campbell (under review) found that American Indians who had attended boarding school as children had higher levels of enculturation compared to others. These outcomes are not directly

associated with mental health, however, they may serve as cultural buffers between trauma and wellness. Research with diverse communities is needed to identify culturally specific responses to historical trauma as well as the strengths and resiliencies that may buffer such trauma among diverse populations.

Race, Social and Psychological Processes and Mental Health

Findings in race and mental health, as we noted earlier are far from consistent, with some studies reporting more symptoms of psychological distress for racial and ethnic minorities, and others reporting no differences (Brown, Sellers, & Gomez, 1999; Vega & Rumbaut, 1991). While we have recognized that social positions such as race, socioeconomic status, gender and age affect exposure to health risk and access to health-related resources, we have yet to specify exactly the *way* in which this occurs or how it is related to other social or psychological processes.

The next level of research in this area should go beyond the more simple debates about race versus socioeconomic status (Takeuchi & Williams, 2003). One strategy is to identify the mechanisms and processes by which race is linked to mental health by conducting race-specific analyses. This would go past a simple mediational strategy to think through and tailor theorizing and research about process to the social, economic and cultural challenges each race and ethnic group confront. This approach is paramount in understanding mental health inequalities. An examination of the underlying mechanisms and processes involved within racial and ethnic groups is a different strategy than that currently used in much of the traditional racial comparative studies in the social and behavioral sciences. Instead of "explaining away" differences or "controlling for" those factors that might account for observed differences in mental health (the most common strategy used to identify factors that may account for racial differences in health

outcomes), this approach explores whether social and psychological factors operate differently within specific racial groups and lead to divergent mental health trajectories and heterogeneity within groups (Kerckoff, 1993; O'Rand & Henretta, 1999).

Social Structure and the Individual

Social causation explanations have been offered to explain the persistent disparities in health outcomes among racial and ethnic groups (House, Kessler, Herzog, Mero, Kenney, & Breslow, 1990; Lieberman, 1985). More recently, a theory of fundamental social causes of health disparities has been offered (Link & Phelan, 1995), which highlights the role of socioeconomic status in observed health inequality and dims the light on "proximal risk factors" (e.g., environmental and behavioral risk factors) that link social location to health. This perspective posits that if proximal factors were eliminated from causal models, the SES-health relationship remains due to the reproduction of the SES-health link through the resources such as money, power, social networks, and prestige. While this framework acknowledges the impact of social positions on more proximal factors, such as neighborhoods, social networks and health behaviors, it offers much less in helping us understand the experience of illness or the role that social actors play in influencing outcomes. To advance our understanding of causal processes, we must understand the social and psychological processes through which structural positions influence the individual. Even if changes in social policy, designed to ameliorate particular environmental and social risk factors (e.g., access to resources, attitudes, health behaviors, neighborhood quality), were to be effective, the relationship between social position and health might not be eradicated because it operates in so many diverse ways (Williams, 1990).

For example, some scholars might accept a wide variety of explanations of the "fundamental social causes of health disparities" that are embedded in the larger social structure, yet not accept a social psychological approach to understanding a person's experience and meaning of illness, and consequently, the coping responses across and within racial and ethnic groups. It may be these differential pathways that can lead to differential outcomes.

The interplay between social structure and social and psychological processes is not a new idea for sociology. The social structure and personality framework (House, 1977, 1981; McLeod & Lively, 2004) links society to the individual through various social and psychological processes that shift the attention away from stable norms and values toward more changeable, continually readjusting social processes. Symbolic interactionism (Hollander & Howard, 2000; Stryker, 1987) further contextualizes the relationship between the individual and society by focusing on how the *meaning* of an event or situation is constructed through the process of interaction of individuals with their environment. It is this interaction that also allows for shifts, flexibility and variation in meaning and appraisal and, consequently, the differential impact of these experiences on individual health.

These mediating processes are certainly influenced by one's location in the social structure. For example, social and psychological resources are unevenly distributed by social status (Mirowsky & Hu, 1996; Turner & Lloyd, 1999). There are, in fact, racial differences in social psychological processes and the determinants of beliefs and attitudes. Race also has implications for numerous subjective states, such as self-esteem and self-efficacy (Hughes & Demo, 1989). Consequently, individuals with access to the same resources do not share the same experiences that may either affect their mental

health or their response to it. Further, resources may reinforce current effects of advantage or disadvantage in some instances and not others. Therefore, we should expect race, as a major structural parameter of social life, to matter in basic social processes that contemporary sociologists usually explore. Failure to attend to those processes that are influenced by race may result in knowledge that reflects a primarily "white" experience of the world (Hunt, Jackson, Powell, & Steelman, 2000). Indeed, the ability to trace the direct and indirect consequences of social structural factors as they are affected by social and psychological processes is consistent with a sociological examination of mental health disparities.

Empirical evidence lends strong support for social and psychological factors such as social support, negative social interactions (e.g., conflict, demands and broken promises) and mastery, as constructs that link social statuses to mental health. Social and psychological resources are thought to increase the likelihood of effective coping and positive health behaviors and potentially buffer or moderate the impact of adverse conditions on mental health outcomes. One hundred years ago, Durkheim's (1897/1951) study of suicide made a significant contribution to the field of sociology. He found that suicides were more prevalent among those with fewer social ties, which in turn, produced a loss of social resources, a reduction in social constraints (based on defined norms and social roles), and ultimately resulted in poor psychological outcomes and increased risk of suicide. Extant reviews of the social support literature since (Cohen & Wills, 1985; House, Umberson, & Landis, 1988; Thoits, 1995) conclude that social support, regardless of the way in which it is measured, has the potential to alleviate the deleterious effects of stress and other undesirable situations on physical, mental, and social outcomes.

A growing body of research also focuses on perceptions of mastery or personal control as important factors influencing mental health. Feelings of mastery have been associated with less psychological distress (Lincoln, Chatters, & Taylor, 2003) and lower rates of depression (e.g., Mirowsky, 1995; Pearlin, Lieberman, Menaghan, & Mullan, 1981) independently and interdependently with social resources like social support. For example, social support theorists (e.g., Thoits, 1985, 1995) maintain that social support can serve to enhance adjustment by increasing one's sense of mastery and involving the individual in active problem-solving. Individuals also maintain a sense of mastery by meeting responsibilities to people in their social network and by receiving assistance from them.

A study by Lincoln and colleagues (2003) is an example of racial differences in social and psychological processes and mental health. Findings from their study reveal divergent predictive models for African Americans and whites. Specifically, social support from relatives indirectly reduced psychological distress by bolstering feelings of personal control among whites. This pattern of relationships did not emerge for African Americans. However, negative interactions with relatives increased psychological distress by eroding feeling of personal control for African Americans; this was not the case for whites. This set of findings not only reveals the distinctive nature of social and psychological processes by race, but also calls into question prior research (within primarily majority samples) which is based on the assumption that the relationships among these factors are similar across racial and ethnic groups.

Research Implications

A structural perspective on the social causes of health disparities recognizes the link between mastery and differential access to power. Despite the recognition that

macrolevel factors (e.g., racism, the economy) influence microlevel experiences (e.g., powerlessness lack on control), few investigators have attempted to examine these links. It may be because microlevel experiences are within the domain of social psychology and less a part of mainstream sociology (Schnitter & McLeod, 2005). However, the issue of structural constraints and their impact on available coping resources is of particular importance for both identifying those life exigencies that are resistant to coping efforts and for understanding the various processes that link race to differential health outcomes.

A new and promising direction in the study of race and mental health disparities examines the negative side of social relationships (Lincoln, Chatters, & Taylor, 2003). Negative interaction refers to unpleasant social exchanges between individuals that are perceived by the recipient as unsupportive, critical, manipulative, demanding, or otherwise inconsequential to their needs. Research on social relationships and mental health suggests that social support and negative interactions are distinct dimensions of social relationships that appear to increase the probability of maladaptive mental health outcomes (Lincoln et al., 2003; Okun & Keith, 1998; Rook, 1984). The majority of studies indicate that, across a variety of samples and indicators, negative social interactions exert a greater effect on mental health than do measures of social support. Evidence suggests that although negative interactions occur less frequently relative to supportive interactions, negative encounters with social network members have the potential to cause emotional distress and to severely increase existing levels of stress (Krause & Jay, 1991). Moreover, the deleterious effects of negative interactions often occur despite the presence of supportive exchanges within an individual's social network.

In sum, to the extent that we are able to decrease negative interactions, enhance supportive relationships and levels of mastery, especially among disadvantaged groups,

we should consequently reduce racial and ethnic disparities in health. However, it is important to recognize the limitations of such an approach as well as highlight its strengths. First, modifying any social or psychological resource is a difficult process. Second, the mechanisms that link race to mental health are not the same across all disadvantaged groups. Finally, the mechanisms that currently link race to health are different than they were in the past and will be different in the future – that is, they are moving targets. Improved access to mental health care and advances in treatment are just a couple of examples of the more recent advances that may differentially impact individuals from diverse racial and ethnic groups.

In addition to providing a more complete view of the dynamics of social status and mental health, recent findings present challenges to traditional ways of thinking about racial differences as well as opportunities to broaden our conceptualization and measurement of these constructs. Studies of mastery, for example, suggest that African Americans may ascribe a different meaning to items that suggest personal control, compared to their white counterparts, because of their higher religiosity (Shaw & Krause, 2001). Within a religious context, then, items suggesting that an individual, rather than a higher power, is primarily responsible for what happens to them may have different meanings and consequently, elicit different responses.

Geographic and Social Places

The past decade has been marked by a resurgence of interest in "place" as a social context for framing analyses of race and health. The attention to social contexts is, in some respects, linked to the development of analytic tools that allow for the assessment of multiple hierarchical forms of statistical associations. For the most part, however, studies supposedly about the effects of place have actually been based on the aggregated

characteristics of individuals as measured in censuses or other surveys (Gieryn, 2000). Typically, the proportion of variance in health behaviors explained by these operationalizations of place have been relatively small, prompting some to suggest that place has only a limited effect on individual behavior. Alternatively, Macintyre, Ellaway and Cummins (2002) and others suggest that weak effects are more likely due to inadequate conceptualization, operationalization, and measurement of place effects. Based on their reviews of theoretical works and empirical analyses, Gieryn (2000) and Macintyre et al. (2002) suggest the need to move to multifaceted conceptions of "place" encompassing geographic location, material form and infrastructure, and meaning.

Place is defined as a geographically located aggregate of people, practices, and built or natural objects that are invested with meaning and value. Place is treated neither as a spatial backdrop for social interaction nor as a proxy for neighborhood variables. Instead, place is viewed as a socio-ecological force with detectable and independent effects on social life and individual well-being (Werlen, 1993). Places reflect and reinforce social advantages and disadvantages by extending or denying life-chances to groups located in salutary or detrimental locales (Gieryn, 2000). Social processes (e.g., segregation, marginalization, collective action) happen through the intervening mechanism of place (Habraken, 1998) with important effects on health and well-being. Massey (2003), for example, argues that inner city racial segregation produces a high allostatic load among African Americans which leads, in turn, to a variety of deleterious health, cognitive, and emotional outcomes. In another vein, reviews of treatment efficacy studies reveal that interventions often do not have the same effects when moved from the clinic to naturalistic social settings (U.S. Department of Health and Human Services,

2001). Such conclusions suggest that treatment effectiveness studies must take very seriously the effects of place on the implementation and outcomes of clinical activity.

The effects of place on health and health behaviors are far from uniform across population groups and health outcomes. Studies of race and place effects need to move toward more nuanced theorizing about the effects of place on health, and toward creating more integrated theories on how place influences health. Accordingly, more theoretical and empirical work is warranted toward understanding specifically how "places" promote social engagement or social estrangement, stress or security, and health or illness within and across racial minority groups.

If place attachments can facilitate social engagement and a sense of security and well-being, the loss of place can have devastating implications for psychological well-being – particularly for members of racial minority populations (Fullilove, 1996). Understanding place – and related constructs of displacement and emplacement – is critical for understanding the role of race, ethnicity, and racial inequalities in society. Displacement occurs when populations are: forced by "push" or "pull" factors to leave places of origin (e.g., immigrants, refugees), place-bound (e.g., prisoners, children in foster care), entrapped in places that become unhealthy over time (e.g., place-bound residents of some central cities) or "without place" (e.g., homeless adults and children). Displacement or dislocation is one of the major sources of poor mental health globally (Mollica, 2000). Racial minority groups are disproportionately represented in different types of displaced groups such as immigrants and refugees, residents in juvenile and adult corrections, homeless populations, and foster care (U.S. Department of Health and Human Services, 2001). Each racial and ethnic group has a different history of displacement, with some groups indigenous to this country and displaced from their

homelands, some brought in as slaves, others migrate to the U.S. of their own volition, and still others seek refuge to avoid genocide, wars, and political persecution.

Over the past three decades, the social, behavioral and medical sciences have documented and described displacement and its consequences among racial groups. Researchers have been less successful in shedding light on how people who have been displaced become emplaced in a new geographic location. While we know, for example, that neighborhoods that have a collective sense of efficacy (Earls & Carlson, 2001), social positions based on income, education or occupation (Krieger, 2001), and positive social relationships can all be factors that help emplace individuals (Pescosolido, 1992), we lack a large body of theoretical and empirical studies that investigates whether they operate in different racial groups in the same way. Equally important, researchers have not adequately investigated the mechanisms unique to different racial groups that help individuals become emplaced in social locations. Moreover, the construct of place has been used quite limited to primarily urban settings and to study limited racial and ethnic groups. Considering place as more than geographic location, allows social scientists and policy makers to consider the distribution of materials resources, political power and control, and social differentiation and exclusion (Polad, Lehoux, Holmes & Andrews, 2005).

RESEARCH IMPLICATIONS

Places reflect and reinforce social advantages and disadvantages by extending or denying life-chances to groups located in salutary or detrimental locales (Kelly, 2003). More basic theoretical and empirical work can identify the important elements of place that are enhancing and constraining for racial groups. Race likely influences the dimensions important for creating a sense of belonging and identity with a particular

geographic space. Conversely, race can be a potent factor in determining dimensions of place that are alienating, exclusionary, and toxic. Indigenous groups, such as American Indians or Native Hawaiians, have histories of displacement from the spiritual resources of their land. Other racial groups were forced to come to the U.S. as slaves or laborers and have endured the legacy of this struggle. Still others, including immigrants and refugees, have often been labeled as "alien" or "foreign" in ways that cast them apart from the "American" identity. Given these unique histories, race may influence the facets that most matter in the meaning of place. To some indigenous groups, for example, a land base to establish spiritual connections with ancestors may be a critical component in influencing connections with a location. A better understanding about these critical factors will help refine theories of place and develop measures that are congruent with how racial groups finding meaning in geographic locations.

Some studies suggest that immigrants tend to have low rates of mental health problems and, over time, their rates increase to levels similar to their native-born counterparts (Ihara & Takeuchi, 2004; Vega & Rumbaut, 1991). While this finding has not been replicated across a wide range of racial and ethnic groups, some intriguing questions are raised about the effects of place on this pattern. On the one hand, since many immigrants may initially settle in racial and ethnic communities, it is possible that residential patterns have a salutary effect on mental health that erodes as immigrants disperse and become more integrated into the mainstream. On the other hand, it is equally plausible that, for immigrants, finding place in the mainstream may include more opportunities to engage in risky behaviors linked to substance use, exposure to stressors such as racial discrimination, and the adoption of western expressions of distress. Since immigration has changed the racial composition of the U.S., studies of place will help us

better understand the processes associated with adaptation, adjustment, and integration and various mental health outcomes.

Over 40 years ago, Erving Goffman made profound observations about how place affects the mental health and treatment of individuals. He noted that people with a serious mental illness have lost contact with their place in society and slowly become divorced from the rituals and interactions that sustain their lives (Goffman, 1971). Detachment from one's place is often associated with alienation, demoralization, and distress (Mirowsky & Ross, 1986). When people with a serious mental illness seek treatment, the treatment setting may serve to reinforce their disconnection with their place in society. Goffman's observations are still insightful for contemporary times and consistent with the personal accounts of people who suffer from mental illness (Holley, 1998; Kaysen, 1994; Sheehan, 1982; Shiller, 1996).

Despite Goffman's early observations, we show little progress in turning his insights into an explicit research agenda on place. We lack systematic investigations about how settings such as clinics and hospitals create places for mental health treatment, especially for different racial groups. Moreover, fewer studies exist about how treatment places are linked negative or successful treatment outcomes. In our view, studies of treatment places are different from past calls to make mental health treatment culturally-sensitive, -appropriate, -competent, or –sensitive. The focus on cultural issues has largely identified attitudes and beliefs of clinicians as major points of intervention (Vega, 2005). Place studies can move beyond attitudes and beliefs by examining the architecture of facilities and how these physical spaces enhance access into treatment and participation in treatment among people with a serious mental illness and their families. While some physical structures are modified to accommodate different groups of people, for example

the use of animal caricatures in pediatric clinics or translated signs in hospitals, many of these attempts lack a theoretical or evidentiary basis and few studies examine their impact on access, participation, and treatment outcomes. Since other disciplines and professions such as geography, anthropology, psychology, psychiatry, social work, nursing, and medicine are interested in the construct of place, the possibilities for sociology to cross disciplinary lines to advance the treatment of mental illness for different racial groups is unlimited.

CONCLUDING COMMENTS

A major contribution of the Sociology of Mental Health to sociology is often neglected; principally because it has more to do with the education and training of sociologists from racial and ethnic minority groups than with more substantive contributions to theory and methods. However, the training program, the Minority Fellowship Program (MFP), has contributed immensely to the development of sociology and to the study of race and mental health. The MFP was started in 1974 with seed funding from the National Institute of Mental Health (NIMH). The program was similar to training efforts started in other disciplines and professions like psychology, nursing, and social work. The program was developed to bring in more predoctoral students from racial and ethnic minority groups which would eventually make sociology as a discipline more diverse. By the 2004-05 program year, the MFP had given 1,257 awards to a diverse group of graduate students: 216 African Americans, 120 Latinos, 28 Native Americans, and 81 Asian Americans. While NIMH intended that the funds would increase the number of minority scholars studying mental health issues, it also had the indirect effect of increasing the number of minority sociologists who went into other fields. A number of MFP students did not focus on mental health issues, but eventually

went on to make contributions to sociology and the scholarship on race. Larry Bobo and Michael Omi are two examples of sociologists who received MFP funding and have been influential in developing general sociological work on race that holds important insights, not always recognized, for the study of race and mental health. More directly, the work of David Williams, and a score of other past MFP fellows have been critical to bringing issues of race and ethnicity to the forefront of mental health research.

Contemporary sociology of race and mental health provides ample opportunities to build from the past or to investigate alternative directions that best explain how these constructs are linked. But, as in the past, the political and social climate will help to shape whether these investigations will prosper in the near future. Sociologists will also have a lot to say by contesting attempts to constrain research on race and mental health. The social mirror provides the metaphor about how we can reflect on our biases and prejudices to make changes in how the study of race is valued and, more importantly, how we make meaningful changes in the racial hierarchy in society. Christopher Edley, Jr. (2001: ix) best captures this spirit:

> Race is not rocket science; it is harder than rocket science. Race demands an intellectual investment equal to the task. It also demands relentlessness in research and teaching that will overwhelm the human tendency to let our differences trigger the worst in our natures.

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